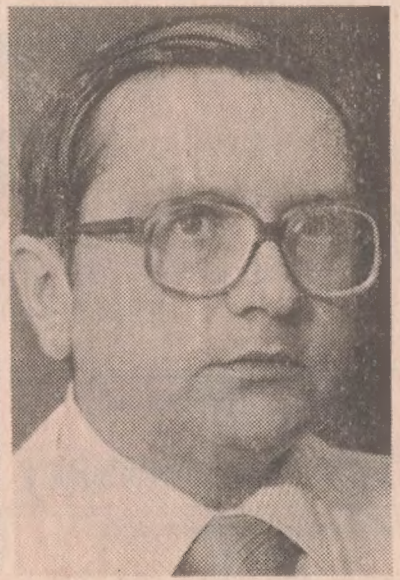
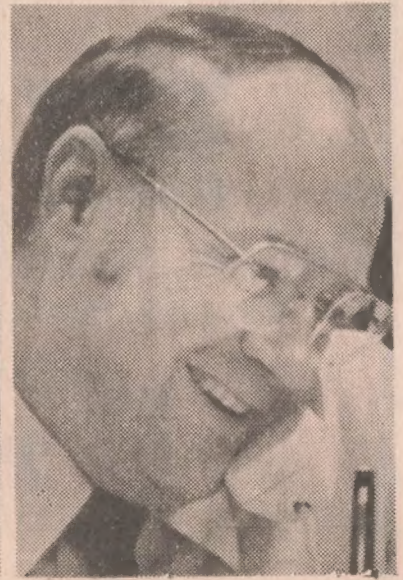
Rural hospitals — endearing but fragile

Stoddard



Joe May



Wayne Ross

■ Second in a series.

By Twila Van Leer
Deseret News medical writer

In 1974, residents of the small southern Utah community of Panguitch raised $300,000 — a monumental sum, considering their numbers — to keep their hospital open.

"We wanted it," said Sybil Taylor, a community volunteer who helped in the effort. "We've always had it. I've been in the hospitals up north, and if I had my choice, I'd be here."

That's what a hospital means to rural Utah — a chance to get health care at home, among family and friends and without having to travel to larger regional centers or the state's busy Wasatch Front. A hospital becomes a center of a small community, one of the institutions that provide cohesiveness and security, said Joe May, administrator of Sanpete Valley Hospital in Mt. Pleasant. His community is also in the midst of a fund-raising campaign to add $450,000 to the coffers for a new hospital. Among the contributors: noted Utah singer Glade Peterson who brought a contingent of Utah Opera singers to the community for a benefit concert. He's a Fairview native and has community loyalties.

Whether the state's small towns can hold onto their facilities has become a real question in an era when America's entire health care industry is in upheaval, responding to economic and ethical pressures.

Many of Utah's small rural hospitals have traditionally operated

See RURAL on B-2

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Rural hospitals — on the edge

...Continued from B-1

...on the thin edge of survival, holding ... on by a financial thread so they can provide needed services to people ...separated by time and distance from larger facilities.

Their problems have been multiplied by new attitudes about health care, changes in reimbursement patterns and a general retrenchment that has brought admissions down significantly.

Rural hospitals have less leeway in their operations, fewer options to adjust to changes. Nationally, experts estimate 200 to 1,000 hospitals may close, many of them small facilities that are being pushed beyond the brink on which they've always teetered.

A trip down Utah's U.S. 89, visiting community hospitals from Nephi to Panguitch, shows most of them holding their own but with administrators who are wary about the future.

One of their prime concerns is how a new prospective payment system initiated by the federal government last fall will affect their budgets. They are just beginning to get their first returns under the so-called DRG (diagnostic related groups) system, and in general, they're coming up short. The DRGs allow only a predetermined reimbursement for services that are defined and categorized into more than 470 groups. If a patient's actual care costs more than the DRG reimbursement, the hospital loses.

"We probably will have a cash flow shortage," said Mark Stoddard, administrator of Juab County Hospital. "We hope over the long haul to find cost-cutting methods, but we will be affected." The Nephi hospital is run by Juab County after an unhappy affiliation experience with a larger hospital system. At present, the county is not subsidizing the hospital through taxes, but Stoddard says that option will have to remain open.

One reason the DRG system may have greater adverse effect on Utah's rural hospitals is that they have a higher proportion of elderly residents in the populations they serve. Senior citizens are the primary group covered by Medicare and they also are the group that traditionally uses more health care resources. Elderly patients often spend longer in the hospital because of the nature of their illnesses and their inability to recover as quickly from illness or injury. A longer hospital stay may tally costs that outrun the amount of money provided by Medicare, and when government-sponsored patients constitute a large part of the hospital's patient load, there are serious financial implications.

Also, said Wayne Ross, administrator of Garfield Memorial in Panguitch, rural hospitals have tended to keep patients somewhat longer than their sister institutions in large cities, to provide an extra degree of precaution.

"We have taken the position that we should take care of all their problems while they're here, because sometimes it's a long way to return if they develop complications after going home," Ross said.

Some of the small hospitals have developed "stepped" programs with different levels of care to see a patient through the degrees of severity of an illness.

For instance, at Sanpete Valley, May said, there has been a home health care program since 1979 — putting that small community ahead of other areas that are only now beginning to recognize the value of home care. A patient may move from an acute care hospital bed to an extended care mode and then to home care as the need for concentrated service diminishes, he said.

The Utah Health Department authorizes some small hospitals to designate a certain number of "swing" beds that can be used for convalescent care as needed, although they are licensed as acute care beds. The reimbursement schedule for the swing beds is different, allowing the hospitals to continue providing care at a lower level without jeopardizing their income.

The hospitals must have certain equipment to qualify for Medicare-Medicaid reimbursement, and maintain minimal staffs, regardless of how many patients are in the hospital at a given time.

The same government agencies that are putting limits on reimbursement put the rural hospitals into a Catch 22 situation by demanding certain standards. The hospitals must have certain equipment to qualify for Medicare-Medicaid reimbursement, and maintain minimal staffs, regardless of how many patients are in the hospital at a given time.

Manpower is always a tough issue in communities where there is a dearth of doctors, nurses and technologists. May calls it his primary problem. By dividing the needs among 53 full- and part-time workers, he is able to handle the peaks and valleys of utilization in the Mt. Pleasant hospital.

A federal program, the National Health Service Corps, has been useful to some Utah communities. NHSC doctors, nurses and other health professionals agree to spend a certain time in an underserved area to repay government loans for medical education. The program often fills a gap temporarily, but NHSC professionals often fill their commitment and then move on, leaving the communities with a continuous recruitment problem. A few stay.

The best solution, Ross said, is to "home grow" doctors and nurses. Residents of small towns who train in the medical disciplines and then return to serve their own communities know what to expect in income and lifestyle and are devoted to small town practice, he said.

Each rural hospital develops referral relationships with larger hospitals in their regions and with the intensive care hospitals along the Wasatch Front. Most of them have contracts with medical specialists who travel to the small hospitals periodically to provide care that isn't available through local doctors, who are almost exclusively primary care physicians.

Within hours, air ambulance out of Salt Lake City puts seriously ill patients into Wasatch Front institutions where critical needs can be met.

Besides being integrated into the larger medical system, the small community hospitals dotted throughout Utah's mountain and desert areas also have undertaken to serve patients in even more remote areas that can't support a hospital. Outreach clinics are provided by each of the hospitals the Deseret News visited, with hospital physicians and mid-level practitioners providing on-site coverage and backup.

For instance, the colored pins planted in the valleys between mountain chains on the Garfield Memorial wall map represent clinics in Escalante, Circleville, Bryce Valley and Long Valley.

The clinics are, in fact, a "loss leader," Ross said. They don't generate sufficient income to pay for themselves. But they do serve as a funnel into the hospital for patients whose needs outstrip clinic capabilities.

In recent years, many Utah communities have addressed the question of affiliating their hospital with a multihospital system. Only a handful continue to operate as city- or county-run facilities. They have their autonomy, but the affiliated hospitals have the backup of a central organization that provides group purchasing of equipment, supplies and liability insurance as well as technical expertise, planning and financing support for expansion.

"We work together to get what we need," said Ross, whose hospital is a part of the Intermountain Health Care system. The IHC central offices provide such things as training in DRG bookkeeping and a computer link that streamlines the small hospital operations.

As the pressures on small hospitals become more acute, there has been some casual conversation about consolidating some of the facilities, May said. Distance is a practical factor that precludes consolidation in some parts of the state. In others, where it might be an option, people tend to identify strongly with their own hospital, he said.

Jon Lee Torgerson, Panguitch mayor when he isn't being simply Daddy to Angela, 7, who was recovering from a tonsillectomy in one of Garfield's tidy, pleasant rooms, demonstrated the point. "When it comes to care, you're never going to get any better," he said. "These are our neighbors."